



Dr. Greg Phillips

Lacy Voth PA-C

Dr. Robert Keller

HIPAA RELEASE FORM

Patient Name _____

SIGN

DATE

Privacy regulations require us to have releases signed by our patients for us to speak with Family members, friends and other relations regarding medical treatment. Each person must be listed individually and by name.

Please print name, relationship and telephone number for each person to whom you are authorizing release of your private health care information.

Name

Relation

Telephone#

Name

Relation

Telephone#

Name

Relation

Telephone#

Name

Relation

Telephone#